



# Registration of Home Births

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## What is included in this packet:

- Information about registering home births in Massachusetts
- Parent Worksheet for Certificate of Live Birth
- Parent Worksheet for Confidential Birth Reporting
- Midwife Worksheet for Confidential Birth Reporting
- Sample Affidavit for Midwife or Other Attendant-at-Birth

## Information about registering home births in Massachusetts

It is extremely important that every child have his or her birth properly registered in a timely manner. If a birth is not registered within 365 days, the process to establish a Delayed Record of Birth is very complicated, and may cause your child difficulties throughout his or her life. If you are registering a birth that occurred more than 365 days ago, check with the city or town clerk where the birth occurred for more information.

Under Massachusetts law, there are four distinct methods for registering births:

1. **Hospital Births**--If a birth occurs in a hospital, the attendant at birth is responsible for reporting to the hospital administrator. The hospital administrator is then responsible reporting to the city or town clerk where the birth occurred and to the Massachusetts Department of Public Health. (Ch.46, s.3, s.3A)
2. **Nonhospital Births Attended by a Physician**--The physician is responsible for reporting to the city or town clerk where the birth occurred and to the Massachusetts Department of Public Health. (Ch.46, s.3B)
3. **Nonhospital Births Attended by Someone Other than a Physician**--The parent(s) is (are) responsible for reporting within 40 days of the birth to the city or town clerk where the birth occurred with appropriate documentary evidence. (Ch.46, s.4, s.6)
4. **Nonhospital Births with Mother and/or Infant Transferred to an Inpatient Hospital for Post Natal Care**--The hospital will prepare the birth certificate and forward it to the city or town clerk where the birth occurred. (Ch.46, s.3, s.3A)

For situation #3 above (a home birth not attended by a physician and where the mother and/or infant were not transferred to a hospital for post-natal care), specific evidence is required by law. These requirements are listed below.

### **Facts of Birth**

One of the following may be used to establish the facts of the birth:

1. Notarized statement of the attendant at birth (any attendant except the father or other close family member, for instance a non-family midwife or friend). This statement must attest to the date, time, and place of the birth as well as the sex of the child and the name of the mother.
2. If the attendant at birth was the father or other close family member (such as the grandmother of the child, or sister or brother of the mother), a notarized statement from the attendant is required which includes those items listed in #1 above, as well as one of the following:
  - a. If other individuals were present at the birth, a notarized statement from a witness stating that they were a witness to the birth at the specified date, time or place.
  - b. If no one else was present, notarized statements from the mother and the attendant stating the facts of the case as well as the fact that no one else was present.
  - c. A notarized statement from a physician who examined the child for postnatal care shortly after birth stating the facts of the birth as listed in #1 above.

### **Place of Birth**

One of the following may be used to establish the place of birth:

1. If the birth occurred at the mother's own residence, proof of her place of residence is required. The best items are street listing, voter registration, or assessor's records for the year of the birth. If none of these are available, check with the city or town clerk where the birth occurred for more information.
2. If the birth occurred at someone else's residence, a notarized affidavit from the resident is necessary stating that the birth took place at their home in addition to proof of residence as described in #1.

### **Marital Status**

Under Massachusetts law, the marital status of the child's parents determines the accessibility of the record as well as the method used to add father's information to the record.

- If the parents are married to each other, a certified copy of their marriage license is required. If a marriage certificate is not available, check with the city or town clerk for more information. The spouse will be listed as the Father/Parent without additional evidence.
- If the parents are not married to each other, there are very specific requirements for (1) removing the spouse's information from the record and/or (2) adding father's information. (These requirements exist regardless of where the birth occurred or who attended the birth.) If this applies to you, contact the city or town clerk for more information.

When you have the necessary evidence and have completed the attached worksheet, contact the city or town clerk in the community where the birth occurred to schedule an appointment to present the evidence to the clerk. The clerk will prepare a birth certificate verification form for your signature(s) and complete the birth registration process. It is important that you carefully review the verification form (and any other forms, if applicable) for accuracy. Once the birth certificate is registered, it is difficult to make corrections.

## **Massachusetts General Law (Chapter 46, selected sections)**

### **Section 3: Physician's record of birth; out of hospital birth**

Every physician or hospital medical officer shall keep a record of birth of every child of which he is in charge showing the information required by section one, to be recorded in the records of birth.

If a birth occurs in a hospital, or if a birth occurs elsewhere and the mother and child are taken to a hospital for postnatal care immediately after the birth, said physician or hospital medical officer shall, within twenty-four hours after such birth, file with the administrator a report, on forms furnished by the commissioner, stating the facts required by section one to be shown on the record of such birth.

### **Section 3A: Hospital administrator's duties; report; signature by parent; penalties**

The administrator or person in charge of a hospital shall be required to obtain, within twenty-four hours after a birth occurring therein or the admittance thereto of a mother and child for post natal care, the report required by section three. If the hospital in which such a birth occurred delivers more than 99 births per year, such report shall be prepared on an electronic system of birth registration approved by the commissioner of public health and transmitted to the state registrar. Said administrator or person in charge shall then forthwith make, or cause to be made, a copy of such report on forms prepared and furnished by the commissioner of public health and shall, within ten days after obtaining such report, file such copies with the clerk or registrar of the city or town wherein the birth occurred. Such copies shall be signed or otherwise verified by the mother in a manner developed pursuant to regulations promulgated pursuant to section 4 of chapter 17, or if she is not able, then by the father or other responsible adult, attesting to the truth and accuracy of the facts appearing in the report. Such copies shall also be signed or otherwise verified, in a manner specified under regulations promulgated pursuant to section 4 chapter 17, by the physician, certified nurse midwife or hospital medical officer in charge of such birth or by an administrator designated by the hospital as overseeing birth registration.

*Amended last: Chapter 64, Acts of 1998*

### **Section 3B: Birth without immediate admittance to hospital for postnatal care; report**

Every physician attending a birth after which the mother and child are not admitted to a hospital for postnatal care immediately after the birth shall, within ten days after such a birth, file with the clerk of the city or town wherein such birth occurred a report on forms prepared and furnished by the commissioner of public health, stating the facts required to be shown on the record of such birth.

*Amended last: Chapter 486, Acts of 1976*

### **Section 4: Birth without attending physician; report; petition; hearing**

The mother of a child who was born without a physician or hospital medical officer in attendance shall, within thirty days after the birth of such child, file a report of such birth, signed and sworn to by her, setting forth the facts required for a record as provided in section one, with the clerk or registrar of the city or town wherein such birth occurred. Such report shall be on a form prepared and furnished to the clerk by the commissioner. Written evidence substantiating such facts shall be required by said clerk or registrar and if he is satisfied as to the truth and accuracy thereof, he shall make a record of such birth. If, however, on the opinion of the clerk or registrar such evidence is not satisfactory, he shall refuse, in writing, to record such a birth. The mother may then present a petition, together with such written refusal and her evidence to establish the validity of such record, to a judge of the probate court for the county where such birth occurred. Written notice shall be given to said clerk or registrar of the time and place of the hearing on such petition. After such hearing, if the court is of the opinion that such birth should be recorded, it shall order such recording. Upon receipt of such order, the clerk or registrar shall make a record of such birth.

*Amended last: Chapter 684, Acts of 1981*

### **Section 6: Notification of births and deaths**

Parents, within forty days after the birth of a child, and every householder, within forty days after a birth in his house, shall cause notice thereof to be given to the clerk of the town where such child is born. The commissioner of children and families, within forty days after the delivery or commitment of an abandoned child or foundling to the department of children and families, shall cause notice of the birth of such child or foundling to be given to the clerk of the town wherein such child or foundling was found. Every householder in whose house a death occurs and the oldest next of kin of a deceased person in the town where the death occurs shall, within five days thereafter, cause notice thereof to be given to the board of health, or, if the selectmen constitute such board, to the town clerk. The keeper, superintendent or person in charge of a house of correction, prison, reformatory, hospital, infirmary or other institution, public or private, which receives inmates from within or without the limits of the town where it is located shall, when a person is received, obtain a record of all the facts which would be required for record in the event of the death of such person, and shall, on or before the fifth day of each month, give notice to the town clerk of every birth and death among the persons under his charge during the preceding month. The facts required for record by section one or section one A, as the case may be, shall, so far as obtainable, be included in every notice given under this section.



Commonwealth of Massachusetts  
 Department of Public Health  
 Registry of Vital Records and Statistics



## Parent Worksheet for Certificate of Live Birth

The information you provide below will be used to create your child's birth certificate. The birth certificate is a permanent document that will be used throughout your child's life to prove his or her age, citizenship, identity and parentage.

It is very important that you provide complete and accurate information for all of the questions. Items marked with an asterisk (\*) will be printed on your child's legal birth certificate, but every item is needed for legal and/or public health purposes. Some of your answers are used by health and medical researchers to study and improve the health of parents and newborn infants. This information is collected in accordance with Massachusetts General Law (c.111, §24B).

**Please print your answers neatly and accurately.** The birth certificate is a permanent legal document that is a record of events and information at the time of your child's birth and may not be changed later except under very limited conditions.

### CHILD Information

**Child's Full Name:** Print your child's name exactly as you want it to appear on his or her birth certificate. Separate the first, middle, and last names in the boxes below:

*First Name:	
*Middle Name: <input type="checkbox"/> Check if your child's certificate will <i>not</i> have a middle name	
*Surname: (Last Name)	*Generational, if any: (e.g., JR, III)

**Child's Facts of Birth:** Enter the date and time your child was born, whether male or female, and indicate whether your child was a singleton or multiple:

<b>*Date of Birth:</b> (e.g., <u>Mar.</u> <u>15</u> <u>2011</u> ) <hr/> Month                      Day                      Year	<b>*Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>*Plurality:</b> <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3-Triplet <input type="checkbox"/> 4-Quadruplet <input type="checkbox"/> Other:
<b>*Time:</b> _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	<b>*Birth Order:</b> (if not single) <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> <input type="checkbox"/> _____ <span style="float: right;"><i>Other</i></span>	

## MOTHER/PARENT Information

This section is used to complete the Mother/Parent fields on the child's birth certificate. The parent that appears in this section must be the delivering mother unless otherwise directed by court order.

**Mother/Parent Full Legal Name:** Enter the name of the parent that will appear in the Mother/Parent section of the child's birth certificate. Separate the first, middle, and surname fields in the boxes below. This name is your full and current legal name that you use for signing legal documents.

<b>*First Name:</b>	
<b>*Middle Name:</b> <input type="checkbox"/> Check if the mother/parent does not have a middle name.	
<b>*Surname: (Last Name)</b>	<b>*Generational, if any: (e.g., JR, III)</b>

**Mother/Parent Telephone:** Please provide telephone numbers for contacting you if there is a problem with your child's birth record. Telephone is not printed on your child's birth certificate.

**Mother/Parent Social Security Number (SSN):** SSN is required by federal law for all birth registrations. SSN is not printed on your child's birth certificate.

<b>Telephone #:</b>	<b>Alternate Telephone #:</b>	<b>SSN:</b> Check if: <input type="checkbox"/> I have never been issued a Social Security #
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**Mother/Parent - Facts of Birth:** Enter the following information about your birth date, your name at the time of your birth, your sex, and where you were born. Place of birth should contain the city/town of birth or local jurisdiction where your own birth certificate is on file. This information is needed for legal registration purposes and is also useful for family genealogical research.

<b>*Date of Birth: (e.g., <u>Mar.</u> <u>27</u> <u>1980</u>)</b> <small>Month                  Day                  Year</small>	<b>*Surname (last name) at <u>your</u> birth or adoption: (Maiden Surname)</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>*Place of Birth:</b>		
<small>Country (Do not abbreviate, unless U.S.)</small>	<small>State or Province (Do not abbreviate)</small>	<small>City/Town or Local Jurisdiction (Do not abbreviate)</small>

**Mother/Parent - Current Marital Status:** Although your marital status does not print on your child's birth certificate, it is necessary to register the record legally and properly. Failure to provide accurate marital status information can cause your child's birth certificate to remain unregistered, causing legal difficulties throughout your child's life.

**Marital Status and Paternity Establishment:**

- If the mother/parent is not married, and was not married within 300 days of the child's birth, a biological father may be added through a *Voluntary Acknowledgment of Parentage* at the time of birth, or at a later date. Both parents must sign this form.
- If the mother/parent is currently married, or was married within 300 days of the birth, the spouse will be listed as the father/parent on the child's initial birth certificate *unless* the mother/parent and spouse sign an *Affidavit of Non-Paternity* and the mother/parent and biological father sign a *Voluntary Acknowledgment of Parentage*.

<b>Marital Status:</b>			
<input type="checkbox"/> Married	<input type="checkbox"/> Divorced:	<small>Date of Divorce:</small>	<small>County/Jurisdiction where filed:</small>
<input type="checkbox"/> Never Married	<input type="checkbox"/> Widowed:	<small>Date of Spouse's Death:</small>	
<b>If married, divorced, or widowed: Is your spouse or former spouse the father/parent of this child?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<ul style="list-style-type: none"> <li>• Questions about the <i>Voluntary Acknowledgment of Parentage</i> or the <i>Affidavit of Non-Paternity</i> may be directed to the City or Town Clerk or the State Registry of Vital Records and Statistics at (617) 740-2600.</li> <li>• Questions about court adjudications of paternity, voluntary acknowledgments, DNA testing, or other questions about paternity, may also be directed to: Department of Revenue, Child Support Enforcement Division, at 1-800-332-2733.</li> </ul>			

**MOTHER/PARENT Information, continued**

**Mother/Parent - Residence:** Your residence is the actual address of the place where you live. Do not use a post office box or other address used for mailing purposes only. The city or town where you live must be listed by its legal and proper name. Do not list a neighborhood, village or other sub-division name. You will be asked for your mailing address in the next section.

<b>*Residence:</b>		
Street number and name (e.g., 9 Ninth Street)		Apartment or unit, if any (e.g., Apt. 9)
Proper City/Town name (e.g., Boston, not Mattapan)	State (Province/state and country if not U.S.) (Do not abbreviate)	Zip Code
<b>County of Residence:</b>	<b>If <u>not</u> in Massachusetts, do you live within city limits?</b>	
In what county do you live?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know	

**Mother/Parent - Mailing Address:** Enter your mailing address if it is different than your residence address. This address does not appear on your child's birth certificate but may be used to contact you if there is a problem with the birth certificate.

<b>Mailing Address:</b>		
Number and Street, PO Box or RR# - Please write the postal delivery address where you receive your mail		
City/Town	State (Province/state and country if not U.S.) (Do not abbreviate)	Zip Code

**FATHER/PARENT Information**

This section is used to complete the Father/Parent fields on the child's birth certificate. It is usually best if the father/parent completes this section of the form.

**Please indicate relationship of the father/parent to the mother/parent:**

<input type="checkbox"/> Married to the Mother/Parent, or married to the mother/parent within 300 days of the child's birth.
<input type="checkbox"/> Not married to Mother/Parent, but will complete a <i>Voluntary Acknowledgment of Parentage</i> or is named by court order.
<ul style="list-style-type: none"> <li>• If the mother/parent is not married, and <i>was not</i> married within 300 days of the child's birth, a father may be added through a <i>Voluntary Acknowledgment of Parentage</i>. Both parents must sign this form.</li> <li>• If the mother/parent is currently married, or <i>was</i> married within 300 days of the birth, to someone other than the father of the child, the spouse will be listed on the child's birth certificate <i>unless</i> the spouse and the mother/parent sign an <i>Affidavit of Non-Paternity</i> <u>and</u> the father and the mother/parent sign a <i>Voluntary Acknowledgment of Parentage</i>, or by proper court order.</li> <li>• If you have questions about paternity or parental status, ask your City/Town Clerk, or contact the Registry of Vital Records and Statistics at (617) 740-2600 or contact the Department of Revenue, Child Support Enforcement Division, at 1-800-332-2733.</li> </ul>

**Father/Parent Full Legal Name:** Enter the name of the parent that will appear in the Father/Parent section of the child's birth certificate and/or on the *Voluntary Acknowledgment of Parentage*. Separate the first, middle, and surname fields in the boxes below. This name is the father/parent's full and current legal name that is used for signing legal documents.

<b>*First Name:</b>	
_____	
<b>*Middle Name:</b>	<input type="checkbox"/> Check if the father/parent does not have a middle name.
_____	
<b>*Surname: (Last Name)</b>	<b>*Generational, if any: (e.g., JR, III)</b>
_____	_____

**FATHER/PARENT Information, continued**

**Father/Parent Social Security Number (SSN):** SSN is required by federal law for all birth registrations. SSN is not printed on your child’s birth certificate.

**SSN:**

Check if:  Father/Parent has never been issued a Social Security #

**Father/Parent - Facts of Birth:** Enter the following information about the father/parent of the child: Birth date, name at the time of father/parent’s birth, sex, and where the father/parent was born. Place of birth should contain the city/town of birth or local jurisdiction where the father/parent’s birth certificate is on file. This information is needed for legal registration purposes and is also useful for family genealogical research.

<b>*Date of Birth:</b> (e.g., <u>Mar. 27 1980</u> ) _____ <i>Month Day Year</i>		<b>*Surname (last name) at father/parent’s birth or adoption:</b> _____	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>*Place of Birth:</b> _____ <i>Country (Do not abbreviate, unless U.S.) State or Province (Do not abbreviate) City/Town or Local Jurisdiction (Do not abbreviate)</i>			

**Father/Parent - Residence:** Residence is the actual address of the place where the father/parent lives. Do not use a post office box or other address used for mailing purposes only. The city or town where the father/parent lives must be listed by its legal and proper name. Do not list a neighborhood, village or other sub-division name.

**Father/Parent residence address is the same as the Mother/Parent.** If not the same, please complete:

<b>Residence:</b> _____ <i>Street number and name (e.g., 9 Ninth Street) Apartment or unit, if any (e.g., Apt. 9)</i>		
_____ <i>Proper City/Town name (e.g., Boston, not Mattapan)</i>	_____ <i>State (Province/state and country if not U.S.) (Do not abbreviate)</i>	_____ <i>Zip Code</i>
<b>County of Residence:</b> _____ <i>In what county do you live?</i>	<b>If <u>not</u> in Massachusetts, do you live within city limits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don’t know	

**Worksheet completed by:**

Please sign: \_\_\_\_\_

Mother/Parent  Father/Parent  Other Relationship \_\_\_\_\_

Please sign: \_\_\_\_\_

Mother/Parent  Father/Parent  Other Relationship \_\_\_\_\_



Commonwealth of Massachusetts  
 Department of Public Health  
 Registry of Vital Records and Statistics



**Parent Worksheet for Confidential Birth Reporting**

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

**Confidential Information**

The following items are required to be collected according to Massachusetts' law (M.G.L. Ch.111 §24B). The law also requires that doctors and other health care providers report additional medical information related to births. This information is kept completely confidential and is used for public health and population statistics, medical research, and program planning. These items never appear on copies of the birth certificate issued to you or your child. Your information is most commonly combined with data from mothers throughout Massachusetts and the United States and is published in tables and charts that do not identify you personally.

The information you provide lets planners know which cities or towns need better public health services and provides facts your doctor needs to know to deliver babies safely. For instance, you help local school departments project numbers of students to plan for your newborn's education, you help doctors and midwives know what effect quitting smoking during pregnancy has on fetal development or which occupations may be hazardous during pregnancy, and you help health providers know which languages are spoken in their area to have translated materials ready.

Your cooperation is urgently needed in order to compile accurate data about Massachusetts families and their newborns. This is the primary source of statistical information about Massachusetts births, which without your help would be unknown. Planners and medical providers use birth data to improve or create new programs and services for mothers and their newborns. Your privacy is taken very seriously. Individual data is never released without the expressed permission of the Commissioner of Public Health and only within very strict guidelines. As an example of an approved use of individual information, the Department of Public Health makes sure that each child receives metabolic screening for certain disorders that should be treated in early infancy to prevent severe disease, such as cystic fibrosis and enzyme deficiencies. You can find out more about this program at <http://www.umassmed.edu/nbs>.

**Your City or Town Clerk's Office will not keep this questionnaire on file. It is not a public record. It will be mailed to the Registry of Vital Records and Statistics for public health statistics.**

**MOTHER/PARENT**

**Mother/Parent Ethnicity:** Information about ethnicities of parents help researchers understand more about genetic conditions, cultures, and locations of existing and new ethnic communities that may affect the availability of quality prenatal care services, outcomes of pregnancies, and future health needs of young children and their families.

**Please indicate your ethnic background(s).** *You may choose more than one.*

- |  |  |
|--|--|
| <input type="checkbox"/> African (specify): _____            | <input type="checkbox"/> Korean  |
| <input type="checkbox"/> African-American                    | <input type="checkbox"/> Laotian   |
| <input type="checkbox"/> American                            | <input type="checkbox"/> Mexican, Mexican American, Chicano                  |
| <input type="checkbox"/> Asian Indian                        | <input type="checkbox"/> Middle Eastern (specify): _____                     |
| <input type="checkbox"/> Brazilian                           | <input type="checkbox"/> Native American (specify tribal nation(s):<br>_____ |
| <input type="checkbox"/> Cambodian                           | <input type="checkbox"/> Portuguese  |
| <input type="checkbox"/> Cape Verdean                        | <input type="checkbox"/> Puerto Rican  |
| <input type="checkbox"/> Caribbean Islander (specify): _____ | <input type="checkbox"/> Russian   |
| <input type="checkbox"/> Chinese                             | <input type="checkbox"/> Salvadoran  |
| <input type="checkbox"/> Colombian                           | <input type="checkbox"/> Vietnamese  |
| <input type="checkbox"/> Cuban                               | <input type="checkbox"/> Other Asian (specify): _____                        |
| <input type="checkbox"/> Dominican                           | <input type="checkbox"/> Other Central American (specify): _____             |
| <input type="checkbox"/> European (specify): _____           | <input type="checkbox"/> Other Pacific Islander (specify): _____             |
| <input type="checkbox"/> Filipino                            | <input type="checkbox"/> Other Portuguese (specify): _____                   |
| <input type="checkbox"/> Guatemalan                          | <input type="checkbox"/> Other South American (specify): _____               |
| <input type="checkbox"/> Haitian                             | <input type="checkbox"/> Other ethnicity(ies) not listed (specify):<br>_____ |
| <input type="checkbox"/> Honduran                            |  |
| <input type="checkbox"/> Japanese                            |  |



**MOTHER/PARENT, continued**

**Mother/Parent Race:** Information about race of parents helps researchers understand more about birth rates, health conditions and other factors relating to race that may affect birth outcomes and health service needs in Massachusetts communities.

**Please indicate your race(s).** *You may choose more than one.*

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native (specify tribal nation(s): _____) | <input type="checkbox"/> Hispanic/Latina/Other (specify): _____  |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> Native Hawaiian                         |
| <input type="checkbox"/> Black   | <input type="checkbox"/> Samoan                                  |
| <input type="checkbox"/> Guamanian or Chamorro   | <input type="checkbox"/> White                                   |
| <input type="checkbox"/> Hispanic/Latina/Black   | <input type="checkbox"/> Other Pacific Islander (specify): _____ |
| <input type="checkbox"/> Hispanic/Latina/White   | <input type="checkbox"/> Other race not listed (specify): _____  |

**Mother/Parent Education:** Information about education of parents helps researchers understand more about trends in age and education levels of Massachusetts parents, choices in delivery methods and assisted reproductive technologies, reading levels required for health education materials, health information needs in schools by district, and other factors that may affect birth outcomes and maternal and child health.

**What is the highest level of schooling that you have completed at the time of delivery?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 8 <sup>th</sup> grade or less            | <input type="checkbox"/> Some college credit, but no degree | <input type="checkbox"/> Bachelor’s degree (e.g., BA, AB, BS)                                       |
| <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> grade | <input type="checkbox"/> Certificate                        | <input type="checkbox"/> Master’s degree (e.g., MA, MSW, MBA)                                       |
| <input type="checkbox"/> High school graduate or GED              | <input type="checkbox"/> Associate degree (e.g., AA, AS)    | <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, JD) |

**Mother/Parent Occupation and Industry:** Information about jobs parents hold helps researchers find out more about how certain occupations and industries may affect birth outcomes. Certain job conditions such as exposures to toxic paints and chemicals, high-stress industries and low income occupations may affect maternal health conditions and be linked to birth defects.

**Usual occupation/job within the past year:**

**In what industry?** *(You may list an industry or a company name):*

*Examples:* computer programmer, cashier, homemaker, unemployed

*Examples:* software company, Smith’s Supermarket, own home

**Mother/Parent Language Preference:** Information about the language in which parents prefer to speak or that they find easiest to read helps public health programs and medical providers be better prepared with appropriate translators and translated information. Identifying neighborhoods and communities with many foreign-speaking residents helps to place translation staff and materials where they are most needed.

**In what language do you prefer to speak when talking about health questions or concerns?**

**In what language do you prefer to read health-related materials?**

- |                            |  |                               |  |
|----------------------------|--|-------------------------------|--|
| <b>English</b>             | <input type="checkbox"/> Speak <input type="checkbox"/> Read | <b>Somali</b>                 | <input type="checkbox"/> Speak <input type="checkbox"/> Read |
| <b>Spanish</b>             | <input type="checkbox"/> Speak <input type="checkbox"/> Read | <b>Arabic</b>                 | <input type="checkbox"/> Speak <input type="checkbox"/> Read |
| <b>Portuguese</b>          | <input type="checkbox"/> Speak <input type="checkbox"/> Read | <b>Albanian</b>               | <input type="checkbox"/> Speak <input type="checkbox"/> Read |
| <b>Cape Verdean Creole</b> | <input type="checkbox"/> Speak <input type="checkbox"/> Read | <b>Chinese</b>                | <input type="checkbox"/> Speak <input type="checkbox"/> Read |
| <b>Haitian Creole</b>      | <input type="checkbox"/> Speak <input type="checkbox"/> Read | (specify dialect): _____      |  |
| <b>Khmer</b>               | <input type="checkbox"/> Speak <input type="checkbox"/> Read | <b>Russian</b>                | <input type="checkbox"/> Speak <input type="checkbox"/> Read |
| <b>Vietnamese</b>          | <input type="checkbox"/> Speak <input type="checkbox"/> Read | <b>American Sign Language</b> | <input type="checkbox"/> Speak                               |
| <b>Cambodian</b>           | <input type="checkbox"/> Speak <input type="checkbox"/> Read | <b>Other</b>                  | <input type="checkbox"/> Speak <input type="checkbox"/> Read |
|                            |  | (specify): _____              |  |

**MOTHER/PARENT, continued**

**Tobacco Use:** Information about tobacco use by mothers before and during pregnancy helps doctors and midwives provide better information to pregnant women on the effects of smoking on birth weight and other birth outcomes. This question will help to find out whether reducing or increasing smoking at different stages during the pregnancy has different results.

**How many cigarettes OR packs of cigarettes did you smoke on an average day during each of the following time periods?**

	Number of cigarettes	or	Number of packs
3 months <u>before</u> pregnancy	_____		_____
First 3 months of pregnancy	_____		_____
Second 3 months of pregnancy	_____		_____
Third trimester (last 3 months) of pregnancy	_____		_____

**Alcohol Use:** This question will help to find out which amounts of alcohol may have an effect on birth weight and other birth outcomes and if drinking at different times during pregnancy has different results. With real data about alcohol use during pregnancy, doctors and midwives can give better advice to pregnant mothers.

**Did you drink any alcohol in the three months before this pregnancy or anytime during this pregnancy?**

Yes  No

*If yes:*

In the three months **before this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week? \_\_\_\_\_

In the **first three months (first trimester) of this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week? \_\_\_\_\_

In the **second three months (second trimester) of this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week? \_\_\_\_\_

In the **third trimester of this pregnancy**, how many drinks (beer, wine or cocktails) did you have in an average week? \_\_\_\_\_

**WIC Food:** Public health program planners would like to know if women sign up for WIC *because* they become pregnant and if receiving WIC food during pregnancy helps mothers deliver healthier babies. Information such as this may help to keep such programs available for women and children.

**Did you receive WIC (Women, Infants & Children) food for yourself because you were pregnant with this child?**

Yes  No  I don't know

**Weight and Maternal and Child Health:** In combination with known statistics about weight gain during pregnancy, public health researchers want to study pre-pregnancy weights to see if some weight ranges result in healthier mothers and babies.

**What was your pre-pregnancy weight, that is, your weight immediately before you became pregnant with this child?** \_\_\_\_\_ lbs.

**Dental Care during Pregnancy:** Public health researchers would like get more information on whether professional teeth cleanings during pregnancy have an effect on newborn health, so that doctors and midwives can better advise women who become pregnant.

**During this pregnancy did you have your teeth cleaned by a dentist or dental hygienist?**

Yes  No

**FATHER/PARENT**

**Father/Parent Ethnicity:** Information about ethnicities and races of parents helps researchers understand more about genetic conditions, cultures, and geographic locations of existing and new ethnic communities that may affect the availability of quality prenatal care services, outcomes of pregnancies, and future health needs of young children and their families.

**Please indicate the father/parent’s ethnic background(s).** *You may choose more than one.*

- |  |  |
|--|--|
| <input type="checkbox"/> African (specify): _____            | <input type="checkbox"/> Korean  |
| <input type="checkbox"/> African-American                    | <input type="checkbox"/> Laotian   |
| <input type="checkbox"/> American                            | <input type="checkbox"/> Mexican, Mexican American, Chicano                |
| <input type="checkbox"/> Asian Indian                        | <input type="checkbox"/> Middle Eastern (specify): _____                   |
| <input type="checkbox"/> Brazilian                           | <input type="checkbox"/> Native American (specify tribal nation(s)): _____ |
| <input type="checkbox"/> Cambodian                           | _____  |
| <input type="checkbox"/> Cape Verdean                        | <input type="checkbox"/> Portuguese  |
| <input type="checkbox"/> Caribbean Islander (specify): _____ | <input type="checkbox"/> Puerto Rican                                      |
| <input type="checkbox"/> Chinese                             | <input type="checkbox"/> Russian   |
| <input type="checkbox"/> Colombian                           | <input type="checkbox"/> Salvadoran  |
| <input type="checkbox"/> Cuban                               | <input type="checkbox"/> Vietnamese  |
| <input type="checkbox"/> Dominican                           | <input type="checkbox"/> Other Asian (specify): _____                      |
| <input type="checkbox"/> European (specify): _____           | <input type="checkbox"/> Other Central American (specify): _____           |
| <input type="checkbox"/> Filipino                            | <input type="checkbox"/> Other Pacific Islander (specify): _____           |
| <input type="checkbox"/> Guatemalan                          | <input type="checkbox"/> Other Portuguese (specify): _____                 |
| <input type="checkbox"/> Haitian                             | <input type="checkbox"/> Other South American (specify): _____             |
| <input type="checkbox"/> Honduran                            | <input type="checkbox"/> Other ethnicity(ies) not listed (specify): _____  |
| <input type="checkbox"/> Japanese                            | _____  |

**Father/Parent Race:** Information about race of parents helps researchers understand more about birth rates, health conditions and other factors relating to race that may affect birth outcomes and health service needs in Massachusetts communities.

**Please indicate the father/parent’s race(s).** *You may choose more than one.*

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native (specify tribal nation(s)): _____ | <input type="checkbox"/> Hispanic/Latino/Other (specify): _____  |
| <input type="checkbox"/> Asian   | <input type="checkbox"/> Native Hawaiian                         |
| <input type="checkbox"/> Black   | <input type="checkbox"/> Samoan                                  |
| <input type="checkbox"/> Guamanian or Chamorro   | <input type="checkbox"/> White                                   |
| <input type="checkbox"/> Hispanic/Latino/Black   | <input type="checkbox"/> Other Pacific Islander (specify): _____ |
| <input type="checkbox"/> Hispanic/Latino/White   | <input type="checkbox"/> Other race not listed (specify): _____  |
|  | _____  |

**Father/Parent Education:** Information about education of parents help researchers understand more about trends in age and education levels of Massachusetts parents, choices in delivery methods and assisted reproductive technologies, reading levels required for health education materials, health information needs in schools by district, and other factors that may affect birth outcomes and children’s health.

**What is the highest level of schooling that the father/parent has completed at the time of the child’s delivery?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 8 <sup>th</sup> grade or less            | <input type="checkbox"/> Some college credit, but no degree yet | <input type="checkbox"/> Bachelor’s degree (e.g., BA, AB, BS)                                       |
| <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> grade | <input type="checkbox"/> Certificate                            | <input type="checkbox"/> Master’s degree (e.g., MA, MSW, MBA)                                       |
| <input type="checkbox"/> High school graduate or GED              | <input type="checkbox"/> Associate degree (e.g., AA, AS)        | <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or professional degree (e.g., MD, DDS, DVM, JD) |

**Father/Parent Occupation and Industry:** Information about jobs parents hold help researchers find out more about how certain occupations and industries may affect birth outcomes. Certain job conditions such as exposures to toxic paints and stress may affect families health conditions and be linked to birth defects.

<p><b>Usual occupation/job within the past year:</b></p> <p><i>Examples: computer programmer, cashier, homemaker, unemployed</i></p> <p>_____</p>	<p><b>In what industry?</b> <i>(You may list an industry or a company name):</i></p> <p><i>Examples: software company, Smith’s Supermarket, own home</i></p> <p>_____</p>
---	---

**BIRTH TRENDS AND TECHNOLOGIES**

**Fertility Treatments and Technologies:** Better information about use of fertility drugs and assisted reproductive technologies will allow researchers to determine trends in the use of new types of treatments. This data will also help obstetricians and their patients know more about what risks and benefits there may be to mothers and newborns, depending on mother’s age, genetic relationship to the child, and other characteristics.

**Did you take any fertility drugs or receive any medical procedures from a doctor, nurse, or other health care worker to help you get pregnant with this current pregnancy? (This may include infertility treatments such as fertility-enhancing drugs or assisted reproductive technology.)**  Yes  No

*If you answered yes:*

**Did you use any of the following fertility treatments during the month you got pregnant with this current pregnancy?**

*Check all that apply:*

- Fertility-enhancing drugs prescribed by a doctor**  
Fertility drugs include Clomid®, Serophene®, Pergonal®, or other drugs that stimulate ovulation.
- Artificial insemination or intrauterine insemination**  
Include treatments in which sperm, but NOT eggs, were collected and medically placed into the birth mother.
- Assisted reproductive technology**  
Include treatments in which BOTH a woman’s eggs and a man’s sperm were handled in the laboratory, such as in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer.
- I was not using fertility treatments *during the month that I got pregnant with this child.***
- Other medical treatment. Please specify:**

**Did any of these apply during this pregnancy?**

*Check all that apply:*

- Anonymous egg donor
- Anonymous sperm donor
- Surrogacy
- None of these apply

**Home Births:** This question will help to find out how many home births were planned and how many were unplanned, to provide statistical information and to make sure that all families have good access to maternal and child health services.

**Did you plan on delivering your baby at home or did you want to have your baby in a hospital or birth center?**

- Yes, I wanted to deliver my baby at home  No, I wanted to deliver my baby in a hospital or birth center

Thank you. Your answers to this questionnaire help to improve health care in Massachusetts.



Commonwealth of Massachusetts  
Department of Public Health  
Registry of Vital Records and Statistics



### Worksheet for Confidential Birth Reporting – Midwife / Attendant at Birth

Please use this worksheet to complete the legal and confidential statistical items collected on the birth certificate.

Items containing an asterisk (\*) appear on the child's legal birth certificate. The remainder are not part of the legal record, but are confidential items collected in accordance with Massachusetts General Law (Ch. 111, § 24B). This information is not retained by the City or Town Clerk; it is mailed directly to the Massachusetts Department of Public Health. All items must be completed.

If you have questions about this worksheet, or any of the items collected on the birth certificate, please contact the Registry of Vital Records and Statistics (RVRS) at (617) 740-2623.

#### CHILD Information

Child's Name:

First	Middle	Last

**Child's Facts of Birth:** Enter the date and time the child was born, whether male or female, and indicate whether the child was a singleton or multiple. If the child's sex is undetermined at birth, contact RVRS for more information.

<b>*Date of Birth:</b> (e.g., <u>Mar. 15 2011</u> ) _____ <i>Month Day Year</i>	<b>*Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Undetermined	<b>*Plurality:</b> <input type="checkbox"/> 1-Single <input type="checkbox"/> 2-Twin <input type="checkbox"/> 3-Triplet <input type="checkbox"/> 4-Quadruplet <input type="checkbox"/> Other: _____
		<b>*Time:</b> <input type="checkbox"/> Military <input type="checkbox"/> AM <input type="checkbox"/> PM

#### MOTHER/PARENT Information

Mother/Parent Current Name:

First	Middle	Last

#### MIDWIFE or Other CERTIFIER Information

\*First Name, Middle Name, Last Name (with Generational, if any):

\*Title:

MD     DO     CNM     Other Midwife     Hospital Administrator  
 Other (specify): \_\_\_\_\_

\*License Number:

\*Type:

At Birth                       Post-Natal                       Certifier Only

National Provider ID:

Mailing Address:

Street number and name or PO Box

City/Town, State

Zip Code

Was the Certifier the Attendant at Birth?     Yes                       No

**ADEQUACY OF PRENATAL CARE**

**Did the Mother have Prenatal Care?**

Yes       No

**Date of First Prenatal Care Visit** (MM/DD/YYYY)

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Total # of Prenatal Care Visits:** \_\_\_\_\_

**Date of Last Prenatal Care Visit** (MM/DD/YYYY)

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**MOTHER'S PREGNANCY HISTORY**

**Mother's Height:** \_\_\_\_\_ feet \_\_\_\_\_ inches

**Date of Last Menses** (MM/DD/YYYY)

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Previous Live Births:**

*Do not include this child or multiples of higher birth order:*

# Now living: \_\_\_\_\_ # Born live, now dead: \_\_\_\_\_

**Date of Last Live Birth** (MM/DD/YYYY)

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**Number of Other Pregnancy Outcomes:**

*Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in this pregnancy.*

# Other Pregnancy Outcomes \_\_\_\_\_

**Date of Last Other Pregnancy Outcome** (MM/DD/YYYY)

Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**PRENATAL CARE PRACTITIONER** (choose all that apply)

- |   |                                     |   |
|---|-------------------------------------|---|
| <input type="checkbox"/> MD – OBN/GYN           | <input type="checkbox"/> MD – Other | <input type="checkbox"/> MD – Family Practitioner |
| <input type="checkbox"/> DO                     | <input type="checkbox"/> CNM        | <input type="checkbox"/> NP                       |
| <input type="checkbox"/> RN                     | <input type="checkbox"/> Midwife    | <input type="checkbox"/> PA                       |
| <input type="checkbox"/> Other – specify: _____ |                                     |   |

**PRIMARY PRENATAL CARE SITE** (choose one)

- Private physician's office
- Community health center (specify name): \_\_\_\_\_
- Health Maintenance Organization (HMO) site (specify name): \_\_\_\_\_
- Other (specify): \_\_\_\_\_
- Hospital clinic (specify name): \_\_\_\_\_

**INFECTIONS Present or Treated in this Pregnancy** (choose all that apply)

**For definitions of the terms listed below, please refer to the Glossary for Hospital Mandatory Birth Reporting.**

Include those present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.

- |   |                                      |   |  |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Chlamydia      | <input type="checkbox"/> Gonorrhea   | <input type="checkbox"/> Hepatitis C                        | <input type="checkbox"/> Syphilis          |
| <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rubella infection during pregnancy | <input type="checkbox"/> None of the above |

**RISK FACTORS for this Pregnancy (choose all that apply)**

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acute or chronic lung disease                 | <input type="checkbox"/> Hypertension, pre-eclampsia                            | <input type="checkbox"/> Previous preterm birth                                 |
| <input type="checkbox"/> Anemia (HCT<30, HGB<T 10)                     | <input type="checkbox"/> Hypertension, eclampsia                                | <input type="checkbox"/> Previous cesarean delivery:<br>If yes, how many? _____ |
| <input type="checkbox"/> Cardiac disease                               | <input type="checkbox"/> Hypertension, gestational ( <i>PIH, preeclampsia</i> ) | <input type="checkbox"/> Other previous poor outcome                            |
| <input type="checkbox"/> Diabetes, Prepregnancy                        | <input type="checkbox"/> Incompetent cervix                                     | <input type="checkbox"/> Renal disease  |
| <input type="checkbox"/> Pre-diabetes                                  | <input type="checkbox"/> Lupus erythematosus                                    | <input type="checkbox"/> RH sensitization                                       |
| <input type="checkbox"/> Gestational diabetes                          | <input type="checkbox"/> Maternal cancers                                       | <input type="checkbox"/> Seizure disorders                                      |
| <input type="checkbox"/> Hemoglobinopathy, non-sickle cell anemia      | <input type="checkbox"/> Maternal PKU   | <input type="checkbox"/> Vaginal bleeding                                       |
| <input type="checkbox"/> Sickle cell anemia                            | <input type="checkbox"/> Oligohydramnios  | <input type="checkbox"/> Weight loss inappropriate for mother                   |
| <input type="checkbox"/> Hydramnios                                    | <input type="checkbox"/> Pre-term labor this pregnancy                          | <input type="checkbox"/> Weight gain inappropriate for mother                   |
| <input type="checkbox"/> Hypercoagulable conditions                    | <input type="checkbox"/> Previous infant with birth defects                     | <input type="checkbox"/> None of the above                                      |
| <input type="checkbox"/> Hypertension, Prepregnancy ( <i>Chronic</i> ) | <input type="checkbox"/> Previous infant 4000+ grams                            |   |
| <input type="checkbox"/> Other (specify): _____                        |   |   |

**PRENATAL TESTS AND PROCEDURES (choose all that apply)**

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Amniocentesis                   | <input type="checkbox"/> Fetal surgery                                 | <input type="checkbox"/> Ultrasound        |
| <input type="checkbox"/> Cervical cerclage               | <input type="checkbox"/> Hospitalization (prenatal for this pregnancy) | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> CVS (Chorionic villus sampling) | <input type="checkbox"/> Tocolysis                                     |  |
| <input type="checkbox"/> Other (specify): _____          |  |  |

**ASSISTED REPRODUCTIVE TECHNOLOGY (ART)**

Did this pregnancy result from infertility treatment?  Yes  No *If "Yes," then check all that apply:*

- |  |   |
|--|---|
| <input type="checkbox"/> Fertility enhancing drugs:<br><ul style="list-style-type: none"> <li>• Progesterone</li> <li>• Gonadotrophins (e.g., Clomid®, Serophene)</li> <li>• Gonadotrophin-releasing Hormone Agonists (GnRH Agonists) (e.g., Synarel, Zolodex)</li> <li>• Gonadotrophins-releasing Hormone Antagonists (GnRH Antagonists) (e.g., Cetrotide)</li> </ul> | <input type="checkbox"/> Artificial insemination<br><ul style="list-style-type: none"> <li>• Fertility treatment in which sperm were collected and placed in the female reproductive tract. Do not include intrauterine insemination.</li> </ul>  |
| <input type="checkbox"/> Intrauterine insemination<br><ul style="list-style-type: none"> <li>• Fertility treatment in which sperm were collected and placed in the woman's uterus.</li> </ul>  | <input type="checkbox"/> Assisted reproductive technology<br><ul style="list-style-type: none"> <li>• Include in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer.</li> </ul> |

**MOTHER'S FINAL PREGNANCY WEIGHT (before delivery)**

What was mother's weight just prior to delivery? \_\_\_\_\_ lbs. (pounds)

**PRENATAL CARE – SOURCE OF PAYMENT**

Name of Health Insurer: \_\_\_\_\_

**Type of Health Plan:** (choose one)

- Non-Managed Care       CommCare       Free Care       Self Pay  
 Managed Care       Health Safety Net       Government       Other (specify type): \_\_\_\_\_

**Type of Managed Care:** (choose one)

- BCBS       EPO       MCD       POS       Unspecified Managed Care  
 CommCare       HMO       MCR       PPO       Other (specify): \_\_\_\_\_

Are Prenatal Care Expenses Paid Through a Government Program?  Yes  No *If "Yes," then select one:*

- Commonhealth       Health Safety Net       Indian Health Service       Medicare       Worker's Compensation  
 Commonwealth Care       Healthy Start       Medicaid/MassHealth       Military (Champus, Tricare VA, etc.)       Other (specify): \_\_\_\_\_

**LABOR AND DELIVERY – SOURCE OF PAYMENT**

Is the Labor and Delivery Source of Payment the same as the Prenatal Care Source of Payment?  Yes  No, *If no:*

Name of Health Insurer: \_\_\_\_\_

**Type of Health Plan:** (choose one)

- Non-Managed Care       CommCare       Free Care       Self Pay  
 Managed Care       Health Safety Net       Government       Other (specify type): \_\_\_\_\_

**Type of Managed Care:** (choose one)

- BCBS       EPO       MCD       POS       Unspecified Managed Care  
 CommCare       HMO       MCR       PPO       Other (specify): \_\_\_\_\_

Are Labor & Delivery Care Expenses Paid Through a Government Program?  Yes  No *If "Yes," then select one:*

- Commonhealth       Health Safety Net       Indian Health Service       Medicare       Worker's Compensation  
 Commonwealth Care       Healthy Start       Medicaid/MassHealth       Military (Champus, Tricare VA, etc.)       Other (specify): \_\_\_\_\_



**COMPLICATIONS of Labor and Delivery** (choose all that apply)

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abruptio placenta                               | <input type="checkbox"/> Dysfunctional labor        | <input type="checkbox"/> Prolonged labor (>=20 hrs)                    |
| <input type="checkbox"/> Anesthetic complications                        | <input type="checkbox"/> Moderate/heavy meconium    | <input type="checkbox"/> Prolonged 2 <sup>nd</sup> stage               |
| <input type="checkbox"/> Antibiotics received by the mother during labor | <input type="checkbox"/> Non-vertex presentation    | <input type="checkbox"/> Premature rupture of the membranes (<=12 hrs) |
| <input type="checkbox"/> Cephalopelvic disproportion                     | <input type="checkbox"/> Other excessive bleeding   | <input type="checkbox"/> Rupture of membrane – prolonged (>24 hours)   |
| <input type="checkbox"/> Clinical chorioamnionitis/ temp >=38C (100.4F)  | <input type="checkbox"/> Placenta previa            | <input type="checkbox"/> Seizures during labor                         |
| <input type="checkbox"/> Cord prolapse                                   | <input type="checkbox"/> Precipitous labor (<3 hrs) | <input type="checkbox"/> None of the above                             |
| <input type="checkbox"/> Other (specify): _____                          |   |  |

**LABOR & DELIVERY PROCEDURES** (choose all that apply)

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Admission to intensive care unit           | <input type="checkbox"/> Epidural or spinal anesthesia     | <input type="checkbox"/> Third or fourth degree perineal laceration            |
| <input type="checkbox"/> Electronic fetal monitoring (external)     | <input type="checkbox"/> Fetal intolerance of labor        | <input type="checkbox"/> Unplanned hysterectomy                                |
| <input type="checkbox"/> Electronic fetal monitoring (internal)     | <input type="checkbox"/> Maternal transfusion              | <input type="checkbox"/> Unplanned operating room procedure following delivery |
| <input type="checkbox"/> External cephalic version:                 | <input type="checkbox"/> Ruptured uterus                   | <input type="checkbox"/> None of the above                                     |
| <input type="checkbox"/> Successful <input type="checkbox"/> Failed | <input type="checkbox"/> Steroids (glucocorticoids)        | <input type="checkbox"/> Other (specify): _____                                |
| <input type="checkbox"/> Induction of labor                         | <input type="checkbox"/> Stimulation/augmentation of labor | _____  |

**METHODS OF DELIVERY** (Questions align with hospital reporting. Not all choices will apply.)

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

**Fetal Presentation at Delivery:**

- Cephalic                       Breech                       Other

**Final Route and Method of Delivery (select one)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Vaginal/spontaneous | <input type="checkbox"/> Vaginal/forceps | <input type="checkbox"/> Vaginal/vacuum                      |
| <input type="checkbox"/> Primary cesarean    | <input type="checkbox"/> Repeat cesarean | <input type="checkbox"/> Vaginal birth after cesarean (VBAC) |

**NEWBORN – MEASUREMENTS**

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

**Birthweight:** \_\_\_\_\_ pounds \_\_\_\_\_ ounces    *or*    \_\_\_\_\_ grams

**Head Circumference:** \_\_\_\_\_ centimeters    **Length:** \_\_\_\_\_ inches

**Obstetric Estimate of Gestation at Delivery** (do not compute from last menses) \_\_\_\_\_ weeks

**APGAR Scores:**                      1 minute: \_\_\_\_\_                      5 minutes: \_\_\_\_\_                      10 minutes: \_\_\_\_\_

**PLURALITY**

**Total Live Births from this Pregnancy:** \_\_\_\_\_    **Total Stillbirths from this Pregnancy:** \_\_\_\_\_

**ABNORMAL CONDITIONS OF THE NEWBORN** (choose all that apply)

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

- |  |  |                           |   |
|--|--|---------------------------|---|
| <input type="checkbox"/> Acidosis                                  | <input type="checkbox"/> Hypotonia                                 | Significant birth injury: |   |
| <input type="checkbox"/> Anemia                                    | <input type="checkbox"/> Hypoxia                                   |                           | <input type="checkbox"/> Skeletal fracture(s)               |
| <input type="checkbox"/> Antibiotics for suspected neonatal sepsis | <input type="checkbox"/> Intracranial hemorrhage                   |                           | <input type="checkbox"/> Peripheral nerve injury            |
| <input type="checkbox"/> Congenital infection                      | <input type="checkbox"/> Jaundice (bilirubin>10)                   |                           | <input type="checkbox"/> Soft tissue/solid organ hemorrhage |
| <input type="checkbox"/> Cyanosis                                  | <input type="checkbox"/> Meconium aspiration syndrome              |                           | <input type="checkbox"/> Erb's palsy                        |
| <input type="checkbox"/> Fetal alcohol syndrome                    | <input type="checkbox"/> Positive toxicology screen                |                           | <input type="checkbox"/> Tachypnea                          |
| <input type="checkbox"/> Hyaline membrane disease/RDS              | <input type="checkbox"/> Seizure or serious neurologic dysfunction |                           | <input type="checkbox"/> None of the above                  |
| <input type="checkbox"/> Other (specify): _____                    |  |                           |   |

**NEONATAL PROCEDURES** (choose all that apply)

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Assisted ventilation immediately following delivery | <input type="checkbox"/> Intubation                                   | <input type="checkbox"/> Phototherapy      |
| <input type="checkbox"/> Assisted ventilation - more than six hours          | <input type="checkbox"/> Newborn given surfactant replacement therapy | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Other (specify): _____                              |   |  |

**CONGENITAL ANOMALIES** (choose all that apply)

For definitions of the terms listed below, please refer to the *Glossary for Hospital Mandatory Birth Reporting*.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anencephaly   | <input type="checkbox"/> Hypospadias                            | <input type="checkbox"/> Limb reduction defect                            |
| <input type="checkbox"/> Hydrocephaly  | <input type="checkbox"/> Renal agenesis                         | <input type="checkbox"/> Other musculoskeletal anomalies (specify): _____ |
| <input type="checkbox"/> Meningomyelocele / Spina bifida                           | <input type="checkbox"/> Cleft lip with or without cleft palate | <input type="checkbox"/> Birth mark/storkbite/Mongolian spot              |
| <input type="checkbox"/> Congenital heart defect (CHD), cyanotic                   | <input type="checkbox"/> Cleft palate alone                     | Down syndrome (Trisomy 21)  |
| <input type="checkbox"/> Other heart malformations (specify): _____                | <input type="checkbox"/> Adactyly                               | <input type="checkbox"/> Karyotype confirmed                              |
| <input type="checkbox"/> Rectal atresia/stenosis                                   | <input type="checkbox"/> Polydactyly                            | <input type="checkbox"/> Karyotype pending                                |
| <input type="checkbox"/> Tracheoesophageal fistula (TEF) / esophageal atresia (EA) | <input type="checkbox"/> Syndactyly                             | Suspected chromosomal disorder  |
| <input type="checkbox"/> Omphalocele   | <input type="checkbox"/> Club foot                              | <input type="checkbox"/> Karyotype confirmed                              |
| <input type="checkbox"/> Gastroschisis   | <input type="checkbox"/> Congenital diaphragmatic hernia        | <input type="checkbox"/> Karyotype pending                                |
| <input type="checkbox"/> Other (specify): _____                                    |   | <input type="checkbox"/> None of the above                                |

### HOSPITAL ADMITTANCE AFTER DELIVERY

#### Maternal Transfer

Was mother transferred to a medical facility after delivery for maternal medical indications?  Yes  No

If yes, specify facility: \_\_\_\_\_

#### Newborn Transfer

Was the infant transferred to a medical facility within 24 hours of delivery for fetal indications?  Yes  No

If yes, specify facility: \_\_\_\_\_

### LIVING STATUS OF NEWBORN

Is the infant living at the time of this report?  Yes  No

Infant admitted to a facility, status unknown

If dead, the date of death: (MM/DD/YYYY) \_\_\_\_\_

### PEDIATRICIAN Information

First Name, Middle Name, Last Name (with Generational, if any): \_\_\_\_\_ Title: \_\_\_\_\_

Health Agency Site (if individual pediatrician is not known): \_\_\_\_\_

Address of Pediatrician or Health Site: \_\_\_\_\_  
*Street number and name or PO Box City/Town, State Zip Code*

### INFANT FEEDING INFORMATION

How is infant being fed? (choose one)  Breast milk only  Formula only  Both breast milk and formula  
 Breast milk and other (specify)  Formula and other (specify)  
 Breast milk, formula and other (specify)  
 Other, specify: \_\_\_\_\_